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Physician freedom of conscience in Manitoba

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The MAiD Act

Manitoba is the only Canadian province with a stand-alone statute that protects health care professionals who refuse to provide services: the *Medical Assistance in Dying (Protection for Health Professionals and Others) Act* (MAiD Act).[1]

The *MAiD Act* is a procedure-specific law applying only to euthanasia and assisted suicide (EAS). It protects all regulated professionals who refuse to provide or "aid in the provision" of the procedures from professional disciplinary proceedings and adverse employment consequences because they have refused on the basis of personal convictions. They remain liable for other misconduct in relation to the refusal.

"Aid in the provision" is not defined. A narrow reading could limit protection against coercion to acts closely associated with the administration of a lethal substance, like inserting an IV line or dispensing lethal drugs. A broad reading could extend it to include facilitation by referral or other means. However, based on the *Janaway*[2] and *Doogan*[3] cases in the United Kingdom (in which the key term, "participate," was restricted to "hands on" activity), a narrow reading of "aid in the provision" is possible.

Professional obligations in relation to refusal are untouched by the law. Regulators remain free to specify obligations that do not prevent or conflict with the *MAiD Act*. Based on a narrow interpretation of "aid," this could include facilitation by referral to an EAS practitioner. This would be unacceptable to objecting professionals who believe that entails complicity in killing patients. However, the College of Physicians and Surgeons of Manitoba (CPSM) has adopted a policy that fully protects physicians who do not want to be involved with EAS for reasons of conscience.

College of Physicians and Surgeons of Manitoba (CPSM)

The College of Physicians and Surgeons regulates physicians, surgeons, clinical assistants and physician assistants in the province. Physicians and surgeons are "members" of the College and clinical and physician assistants are "associate members." However, the College's *Standards of Practice of Medicine* refers to all collectively as "members."[4] The provisions considered here originally used the term "member" but now use the term "registrant", which is undefined. For present purposes it is assumed that the terms are equivalent.

Code of Ethics

The College has formally adopted the *Code of Ethics and Professionalism* of the Canadian Medical Association (CMA).[5] The CMA has maintained that objecting physicians are not obliged to refer patients for morally contested services.[6] The *Code* includes the following provisions concerning physicians' exercise of freedom of conscience:

> 3. Act according to your conscience and respect differences of conscience among your colleagues; however, meet your duty of non-abandonment to the patient by always acknowledging and responding to the patient's medical concerns and requests whatever your moral commitments may be.
>
> 4. Inform the patient when your moral commitments may influence your recommendation concerning provision of, or practice of any medical procedure or intervention as it pertains to the patient's needs or requests.[7]

The CMA's understanding of the duty of non-abandonment and obligation to respond to patients' concerns and requests is articulated in the Association's policy on EAS, *Medical Assistance in Dying*:

> a. The CMA believes that physicians are not obligated to fulfill a patient's request for assistance in dying but that all physicians are obligated to respond to a patient's request. This means that physicians who choose not to provide or otherwise participate in assistance in dying are:
>
> > i. not required to **provide it**, or to **otherwise participate** in it, **or to refer** the patient **to a physician or a medical administrator who will provide assistance in dying** to the patient; but
> >
> > ii. are still required to fulfill their duty of non-abandonment by responding to a patient's request for assistance in dying.
>
> There should be no discrimination against a physician who chooses not to provide or otherwise participate in assistance in dying.[emphasis added]
>
> b. The CMA believes that physicians are obligated to respond to a patient's request for assistance in dying in a timely fashion. This means that physicians are obligated to, regardless of their beliefs:
>
> > i. provide the patient with complete information on all options available, including assistance in dying;
> >
> > ii. advise the patient on how to access any separate central information, counselling and referral service; and
> >
> > iii. transfer care of the patient to another physician or another institution, if the patient requests it, for the assessment and treatment of the patient's medical condition and exploration of relevant options. . . [8]

This provision recognizes an obligation to provide information necessary to enable informed

decision-making and patient-initiated transfers of care to a physician or institution chosen by the patient. The expectations would not be problematic for most objecting physicians. The same is true of the further requirements to transfer medical records to those accepting care, to act in good faith and inform patients of their views.

For many objectors, it is essential that the "separate information, counselling and referral service" NOT be a dedicated EAS service, or, at least, that they are not required to provide contact information for a dedicated EAS service.

Conscience-based objection

The practice standard *Good Medical Care* addresses physician freedom of conscience.[9] The policy states that registrants who, based on their "personal values or beliefs," object to participating in a legal medical treatment or procedure a patient "needs or wants" may refuse to provide it, refuse to refer the patient to a registrant who will provide it, and refuse "to personally offer specific information about it."

It is reasonable to understand "provide" to include "assist in providing." The protection afforded by the standard covers every form of involvement that objecting registrants may deem morally unacceptable. Indeed, with respect to offering information it goes further than many objecting registrants would require. Most are willing to provide information necessary to enable informed medical decision-making, and this is presumably what is meant by "specific information."

Providing information is not always a morally neutral act, a point recognized by the General Medical Council of the United Kingdom[10] and the American Medical Association.[11] Allowing objecting registrants to refuse to personally provide specific information may have been intended for the benefit of those who have difficulty establishing what kind of information they can provide without incurring moral culpability.

The policy does not require registrants to disclose their objections to patients unless they refuse to refer them to a registrant who will provide the contested service or are unwilling to personally provide specific information about it. If they are unwilling even to personally provide specific information, they must

> (a) "clearly and promptly" disclose their objection to the patient of their refusal;
>
> (b) provide the patient with timely access to a source of reliable information about the morally contested procedure and available options;
>
> (c) continue to provide care unrelated to the contested service as long as it is needed or until another member has assumed responsibility for the patient;
>
> (d) if authorized by a patient, make relevant medical records available to members responsible for medical care and treatment;
>
> (e) document all interactions in the medical record, "including details of any refusal and any resource(s) to which the patient was provided access."[12]

The standard recognizes the key distinction between providing necessary information to patients,

which must be done personally or by delegation, and providing or facilitating a procedure or service to which a registrants objects for reasons of conscience, which is not required.

Medical Assistance in Dying (Euthanasia and assisted suicide)

The CPSM incorporated the policy on conscientious objection directly into its EAS standard, adding a provision for objecting physician assistants and clinical assistants. They are required to notify their supervising physician if a patient requests information about or access to EAS services.[13]

Non-abandonment and medical emergencies

The duty of non-abandonment within the context of conscientious objection is addressed in the CMA's *Code of Ethics and Professionalism* and explained in the CMA policy *Medical Assistance in Dying*.

The College does not recognize conscientious objection in relation to a registrant's duty to render assistance in an emergency or medical emergency. This is described in the practice standard Duty to Assist in an Emergency.[14] The policy distinguishes between an "emergency" (in which a number of people may be involved and there may be a need for medical treatment or expertise) and a "medical emergency" (which involves at least one patient in need of immediate medical intervention).

"Emergency" is defined as "a present or imminent situation or condition that requires prompt action to prevent or limit the loss of life or harm or damage to the safety, health or welfare of people."

A "medical emergency" is "a sudden injury, illness or complication demanding immediate or early medical care to save life or to prevent serious disability, pain or distress."

Notes

1. *Medical Assistance in Dying (Protection for Health Professionals and Others) Act* , CCSM c M92, online: <http://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=m92>.

2. *R v Salford Health Authority, Ex p Janaway* [1989] AC 537, online: <http://www.bailii.org/uk/cases/UKHL/1988/17.html>.

3. *Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland)* [2014] UKSC 68 at para 37—38, online: <https://www.supremecourt.uk/cases/docs/uksc-2013-0124-judgment.pdf#page=16>.

4. The College of Physicians and Surgeons of Manitoba, *Standards of Practice in Medicine*, Winnipeg: CPSM, 2019 [*Standards*], at Standard of Practice: Definitions, online: <https://cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Definitions.pdf>.

5. College of Physicians and Surgeons of Manitoba, "Code of Ethics" (2022), CPSM (website), online: <http://www.cpsm.mb.ca/laws-and-policies/code-of-ethics>.

6. Sean Murphy, "Canadian Medical Association and Referral for Morally Contested Procedures" (20 Oct 2022), Protection of Conscience Project (website)., online: <https://www.consciencelaws.org/ethics/ethics098-000.aspx>.

7. The Canadian Medical Association, *CMA Code of Ethics and Professionalism,* Ottawa: CMA, 2018, online: <https://policybase.cma.ca/link/policy13937>.

8. The Canadian Medical Association, *Medical Assistance in Dying,* Ottawa: CMA, 2017, online: <https://policybase.cma.ca/link/policy13698>.

9. *Standards*, *supra* note 4 at Standard of Practice: Good Medical Care, 10, online:<https://cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Good%20Medical%20Care.pdf>.

10. "Organ trade GP suspended", *BBC News* (15 October, 2002), online: <http://news.bbc.co.uk/2/hi/health/2329447.stm>.

11. *Bucklew v Precythe* 139 S Ct 1112 [2019] (Brief of American Medical Association, Amicus Curiae, In Support of Neither Party at 11, last para), online: <https://www.supremecourt.gov/DocketPDF/17/17-8151/55061/20180723105907668_17-8151%20tsac%20AMA.pdf#page=17>

12. *Standards*, *supra* note 4 at Standard of Practice: Good Medical Care, 10, online: <https://cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Good%20Medical%20Care.pdf>.

13. *Standards*, *supra* note 4 at Standard of Practice: Medical Assistance in Dying, 1, online: <https://cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Medical%20Assistance%20in%20Dying%20(MAID).pdf>.

14. *Standards*, *supra* note 4 at Standard of Practice: Duty to Assist in an Emergency, online: <https://cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Duty%20to%20Assist%20in%20an%20Emergency.pdf>.